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| Case Number: | CM14-0089785 | | |
| Date Assigned: | 09/10/2014 | Date of Injury: | 12/23/2009 |
| Decision Date: | 10/03/2014 | UR Denial Date: | 05/23/2014 |
| Priority: | Standard | Application Received: | 06/13/2014 |

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to an expert reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer is Board Certified in Occupational Medicine and is licensed to practice in Illinois. He/she has been in active clinical practice for more than five years and is currently working at least 24 hours a week in active practice. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

The injured worker is a 57 year-old morbidly obese man with a date of injury of Dec 23, 2009 who was involved in a motor vehicle accident. He complained of neck pain, shoulder pain, low back pain and knee pain. He has decreased sensation in his left mid-anterior thigh, left mid lateral calf and left lateral ankle with bowel and bladder incontinence. An exam on July 31, 2014 showed the worker primarily complained of low back pain, with multiple diffuse musculoskeletal complaints, including numbness of bilateral upper extremities and left lower extremity, and tingling of both bilateral upper extremities and bilateral lower extremities. Specifically, his back pain radiates down both legs to ankles 80% of the time, worse with activity. His diagnoses include lumbar facet hypertrophy, lumbar radiculopathy, chronic lumbar strain, chronic cervical strain, cervical radiculopathy, bilateral shoulder strain, bilateral hip strain, bilateral knee strain and obstructive sleep apnea.

IMR ISSUES, DECISIONS AND RATIONALES

The Final Determination was based on decisions for the disputed items/services set forth below:

MRI (Magnetic Resonance Imaging) of the left shoulder with contrast: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 195-209, Chronic Pain Treatment Guidelines Chronic Pain Page(s): 4.

Decision rationale: The evidence based guidelines indicate that magnetic resonance imaging (MRI) of the shoulder is indicated when there are red flag findings on history or examination that raise suspicion of a serious shoulder condition or referred pain, physical evidence of tissue insult or nerve damage, failure to progress in a strengthening program, or prior to surgery to clarify the anatomy. The injured worker has sharp left shoulder pain 80% of the time that radiates to the upper back. It interferes with his ability to lift, reach, carry, pull and push. He also has decreased range of motion to 90-degrees of abduction and flexion, and 30-degrees of extension that support the need for imaging. Therefore, the request for a magnetic resonance imaging (MRI) scan is medically necessary and appropriate.

Lumbar epidural steroid injection (LESI) at unspecified levels: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural Steroid Injections.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural Steroid Injections Page(s): 46.

Decision rationale: Per the Medical Treatment Utilization Schedule (MTUS), epidural steroid injections are recommended as an option for treatment of radicular pain (defined as pain in dermatomal distribution with corroborative findings of radiculopathy). The purpose of epidural steroid injections (ESI) is to reduce pain and inflammation, restoring range of motion and thereby facilitating progress in more active treatment programs, and avoiding surgery, but this treatment alone offers no significant long-term functional benefit. This worker has back pain with radiculopathy. Therefore, the lumbar epidural steroid injection (LESI) is medically necessary. New documentation is attached.

Shockwave therapy to treat the neck 1 times 6: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 203. Decision based on Non-MTUS Citation Official Disability Guidelines http://www.aetna.com/cpb/medical/data/600_699/0649.html

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Ankle & Foot, Extracorporeal shock wave therapy (ESWT) Official Disability Guidelines (ODG) Shoulder, Extracorporeal shock wave therapy (ESWT) Maffulli G, Hemmings S, Maffulli N. Assessment of the Effectiveness of Extracorporeal Shock Wave Therapy (ESWT) For Soft Tissue Injuries (ASSERT): An Online Database Protocol. Transl Med UniSa. 2014 Apr 8;10: pages 46-51. Lee S, Lee D, Park J. Effects of extracorporeal shockwave

Decision rationale: Extracorporeal Shock Wave Therapy (ESWT) is not addressed in the Medical Treatment Utilization Schedule (MTUS). The Official Disability Guidelines (ODG) supports shockwave therapy for plantar fasciitis and calcific tendinitis of the shoulder. This worker's cervical exam shows significant limitation in range of motion, however, there is no peer-reviewed evidence to support use for the cervical spine.

Physical therapy to treat left shoulder and neck 2 times 6: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical medicine Page(s): 98-99.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 195-209. Decision based on Non-MTUS Citation Chronic Pain Medical Treatment Guidelines Shoulder Complaints, page 4

Decision rationale: The evidenced based guidelines recommend physical treatment methods, activities and exercise for shoulder complaints. This worker has sharp left shoulder pain 80% of the time that radiates to the upper back that interferes with his ability to lift, reach, carry, pull and push. He also has decreased range of motion to 90-degrees of abduction and flexion, and 30-degrees of extension that support the need for supervised therapy. Therefore, the requested physical therapy sessions are medically necessary.

Low back brace: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 287-301, Chronic Pain Treatment Guidelines Low Back Complaints Page(s): 6.

Decision rationale: Per the Medical Treatment Utilization Schedule (MTUS), lumbar supports have not been shown to have any lasting benefit beyond the acute phase of symptom relief. This injured worker's injury is almost 5 years old, and there is no documentation of an aggravation or exacerbation. Therefore, the low back brace is not medically necessary.

Home health care for 4 hours per day (5 days per week): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Home health services, Page(s): 51.

Decision rationale: Per the Medical Treatment Utilization Schedule (MTUS), Home health services are recommended only for otherwise recommended medical treatment for patients who are homebound, on a part-time or "intermittent" basis, generally up to no more than 35 hours per week. Medical treatment does not include homemaker services like shopping, cleaning, and laundry, and personal care given by home health aides like bathing, dressing, and using the bathroom when this is the only care needed. Per the provided documentation, this injured worker does not exhibit difficulties with activities of daily living (ADLs), medical treatments at home or

functional deficits that require professional health care services. Therefore, this request is not medically necessary.

Orthopedic follow up visit: Overturned

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 287-288, Chronic Pain Treatment Guidelines Low Back Complaints, Page(s): 6.

Decision rationale: Per the Medical Treatment Utilization Schedule (MTUS), primary care or occupational physicians can effectively manage acute and subacute low back problems conservatively in the absence of red flags. However, the Official Disability Guidelines (ODG) supports orthopedic follow-up visits when the patient is actively being treated, which the injured worker appears to be. Therefore, the request is medically necessary.